



**Building Diabetes Care  
Partnerships between Tribes  
and Contract Health Service  
(CHS) Providers:**

**Sharing Patient Information to  
Improve Continuity of Quality Care  
for American Indians**

August, 1999

This document is the result of a collaborative effort involving the following organizations:

**Houlton Band of Maliseet Indians, Houlton, Maine**  
**Aroostook Band of Micmac Indians, Presque Isle, Maine**  
**Indian Health Service, Nashville Area Office of Public Health**

Special thanks and appreciation are extended to the following individuals for their active involvement in, and ongoing support of, this project:

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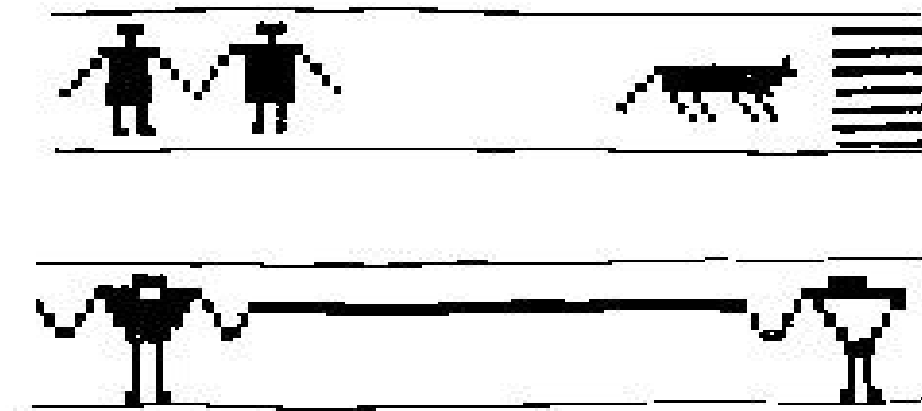
# **Building Diabetes Care Partnerships between Tribes and Contract Health Service (CHS) Providers: Sharing Patient Information to Improve Continuity of Quality Care for American Indians**

## **Introduction**

Many tribal health departments rely on primary care providers in the private sector to care for their tribal members with diabetes. At the same time, many tribal health departments have resources that can improve the care for persons with diabetes. This handbook is a guide for tribes who wish to coordinate services for their tribal members with diabetes and to measure the impact of these efforts on the quality of diabetes care. The steps are based on the actual experience of two tribes in Maine. Input was also obtained from several tribal health programs in the Indian Health Service (IHS) Nashville Area regarding the specific patient information that should be collected from CHS providers and how it could be used for case management. A summary of this information is included in the Appendix in the form titled: *Diabetes Data and Case Management For CHS Providers*.

An effective partnership requires that CHS providers and tribal health departments share information to help individual patients receive comprehensive services. To do this, tribal health departments must “do their homework” and lay a foundation of diabetes expertise in the community in preparation for becoming case managers, or partners in diabetes care. The purpose of this handbook is to guide tribal health professionals and administrators through this process.

Included in the appendix are samples of the actual documents used in Maine. They can be adapted by others to suit their local communities and health care environments.



## **Table of Contents:**

Step 1	Taking an Inventory of Tribal Health Department Diabetes Resources
Step 2	Managing Tribal Diabetes Registries and Measuring Care
Step 3	Enlisting Community Support for Diabetes Care Partnerships
Step 4	Introducing Diabetes Care Partnerships to Primary Care Providers
Step 5	Working with Primary Care Providers to Establish and Maintain Partnerships

## **Appendices:**

### **A. Resource Materials**

1. IHS Standards of Care for Diabetes and Assessment of Diabetes Care, 1999 (Diabetes Data and Case Management for CHS Tribes)
2. American Diabetes Association (ADA) Position Statement on Diabetes Care and Measures Used for Provider Recognition by ADA
3. Diabetes Data and Case Management for CHS Providers
4. Data Collection Instruments and Flow Sheet

### **B. Samples from Maine**

Maine Tribal Health Department Inventory of Diabetes Resources  
Release of Information Form  
Partnership Agreements (2)  
Agenda and Objectives for Initial CME Program



**Step 1:**

***Taking an Inventory of the Diabetes Resources at the Tribal Health Department***

It is very important for a tribal health department to be able to list all of the diabetes-related services available for tribal members, and communicate this information to Contract Health Service (CHS) providers. Even if your health department has very limited resources, you are still able to help in case management by encouraging and informing your tribal members with diabetes to get the regular, comprehensive preventive care recommended by the Indian Health Service (IHS) and American Diabetes Association (ADA) guidelines.

One way to start your inventory of diabetes services is to use a checklist like the one shown below. Once you have identified the specific services you provide, explain each in one or two brief sentences. Pretend you are orienting a new primary care provider to your community and assume that this provider knows nothing about tribal services. A sample of a tribal inventory used in Maine is included in the Appendix.

<b><i>Diabetes Services</i></b>	<b><i>How does primary care provider refer?</i></b>
<b>Diabetes Education</b>	
<b>Self Blood Glucose Monitoring (training/provision of meters, etc.)</b>	
<b>Nutrition Counseling (diabetes/lipid lowering/weight management, etc.)</b>	
<b>Exercise Program</b>	
<b>Dental Examination and Care</b>	
<b>Immunizations (pneumovax; tetanus/ diphtheria; yearly flu shots; PPD testing )</b>	
<b>Community Health Representatives (CHR) (home visits/transportation/education, etc.)</b>	
<b>Home Blood Sugar/Blood Pressure Checks</b>	
<b>Foot Care/Monofilament Testing</b>	
<b>Diabetes Screening</b>	
<b>Social Services/Behavioral Health Counseling</b>	
<b>Other Services ?</b>	

## **Step 2:**

### ***Managing Tribal Diabetes Registries and Measuring Care***

In order for a tribal health department to provide good diabetes “case management”, it is important to have a list of tribal members with diabetes compiled in some form of a registry. A computerized diabetes registry can be set up using the *Patient Care Component (PCC) Diabetes Management System* of the IHS Resource Patient Management System (RPMS). It is also important to be familiar with the IHS Diabetes Care and Outcomes Audit. Contact your IHS Area Diabetes Consultant(s) for more information or assistance with the diabetes registry and the diabetes audit.

The tribes in Maine actually did a preliminary IHS Diabetes Care and Outcomes audit to present to their providers. The audit was used to compare the diabetes care received by tribal members in Maine to the IHS Diabetes Standards of Care, and to the quality of diabetes care provided by IHS/tribal health programs nationwide. Although the information was incomplete, it formed the basis for a discussion on the importance of quality, comprehensive care. The latest computerized diabetes audit program and instruction manual is available from your IHS Area Diabetes Consultant(s), and the Audit ‘99 Assessment Form is included in the Appendix of this handbook. The audit program is written in public domain (non-copyrighted) software called *Epi-Info*, and is free. The primary care providers in the community generally do not have access to this kind of data and are eager to see information relating to quality care.

#### **Make sure you have answers to these questions:**

- How will the tribal health department record, maintain, and utilize diabetes data in cooperation with the local primary care providers? What specific information, or cumulative data reports, will the tribal health department share with the providers and how will this benefit them?
- The first step is to make sure you have a diabetes registry. Will you use RPMS? If not, then arrange an alternative, simple way to maintain current information on your tribal members with diabetes. Who will update the registry? Have they been trained in how to do this?
- Will a questionnaire or a flow sheet be used to gather data? (Examples of both are provided in the Appendix.)
- How will data be maintained and filed to assure privacy? Will you use RPMS? If so, have staff been trained in data entry, coding, and information retrieval from the system? (Your IHS Area Diabetes Consultant(s) can provide, or refer, you to a source of RPMS training.)
- How will releases of information be handled? It is important that all patients, including those with alternate resources such as Medicaid, Medicare, or private insurance, sign a release of information to allow the providers and the health department to share information. If a tribal member is receiving care under Medicare or Medicaid, he/she should also be included and asked to sign a release. Make sure everyone has a current copy on file. State regulations differ regarding the content and duration of authority for a release of information form. Your local hospital is a good place to start to make sure your release of information form meets all the requirements. An example from Maine is provided in the Appendix.
- Who will generate data reports, and on what scheduled frequency, for providers? Can you run the IHS audit or will you need help from the Area Diabetes Consultant(s)?

### **Step 3:**

### ***Enlisting Community Support for Diabetes Care Partnerships***

Sometimes primary care providers regard tribal health departments as insurance companies with no other function than to pay the bills. In order to establish diabetes care partnerships, it is important for the tribal health department to increase its visibility in the larger health care community.

#### **Gaining visibility**

It is important for tribal health departments to lay the groundwork necessary for their programs and services to achieve “constructive visibility” in the greater community. This involves networking with other local health care organizations and groups. For example, participation by tribal health staff in health fairs and screening events held in neighboring towns and cities can be helpful in gaining visibility, as well as establishing relationships and lines of communication that will be beneficial in the future. Often, the local hospital has a discharge planner who is willing to coordinate with a contact at the tribal health department to arrange follow-up care for hospitalized tribal members. (There may also be a diabetes education program sponsored by the local hospital.) A tribal community health nurse, or other health professional familiar with diabetes care, can act as a liaison by initiating these contacts. Take note!: *Doing what you say you will do*, promptly, is also key to establishing the visibility and credibility of the tribal health department.

#### **Gaining visibility and credibility in diabetes care**

An important aspect of getting involved includes the tribe’s ability to access diabetes resources through a network of competent professionals connected, either directly or indirectly, to the tribal health system. This network includes federal agencies, like IHS, that have special interests and expertise in providing diabetes care for Indian people, as well as other state and local agencies or private groups and foundations. For example, techniques such as monofilament screening for high-risk feet have been implemented at IHS/tribal facilities for a number of years and are only now becoming part of standard practice in the greater health care community. Tribes can assist private providers in accessing new advances in diabetes information and techniques through linkages with the IHS Diabetes program and all its resources. In addition, tribes can assist the providers in developing a referral system back to the tribal facility so these providers will have access to a broader range of tribal services and professional staff (i.e., registered dietitians, health educators, CHR’s, and behavioral health counselors). By marketing these services to CHS providers for referral and follow-up care for their Indian patients, the quality of comprehensive preventive diabetes care will improve. Some potential resources are listed in the box below:

**--IHS Area Diabetes Consultants**

**--IHS Diabetes Program web sites and clearinghouse**

**--State Diabetes Control Programs funded by the CDC**

**--American Diabetes Association local/regional chapters**

**--Hospitals**

**--Drug companies\***

**--Blood glucose  
meter reps.\***

\*There are many new developments in diabetes and most companies are happy to assist tribes in providing educational sessions to update primary care providers. Federal officials cannot ask for such help, but tribes can initiate these contacts directly.

#### **Step 4:**

### ***Introducing Diabetes Care Partnerships to Community Providers***

#### **Reaching out to the Primary Care Community**

It is important that individuals understand the concept of case management and shared care. Many primary care providers do not have adequate time and resources to provide comprehensive diabetes clinical care, education, and preventive services at the level recommended by the IHS Diabetes Standards of Care and the ADA Provider Recognition Program. A packet of up-to-date materials can be helpful for busy primary care providers. The Tribe's willingness to assist and share resources, for the benefit of the individual patient, was welcomed in Maine. The inventory is needed to specify what specific services are offered by the Tribe. It is important that the partnerships be framed as part of an effort to improve patient care, and not perceived as a burdensome or punitive review. The ability to take a periodic "snapshot" of care through the audit process is an additional benefit for the tribal health department to ensure that *all* tribal members with diabetes are receiving comprehensive preventive services.

#### **Organizing the Formal Presentations**

The Maine tribes set the stage by sponsoring a dinner presentation for providers in the community. Tribal health staff partnered with a local hospital to arrange for continuing medical education credits (CME's); this proved to be an incentive that encouraged provider participation. Program announcements and invitations were printed and mailed to hospitals, physicians, and medical groups in the area who provided diabetes-related services for tribal members. The educational portion of the presentation offered a practical update on Type 2 diabetes, new medications, and effective treatment strategies. It was approached from the perspective of everyday clinical practice and was approximately forty-five minutes in length. The second portion of the presentation focused on quality benchmarks in diabetes care, highlighting the IHS experience with diabetes standards of care and measurement tools. The current diabetes audit results from the Micmac and Maliseet Tribes were presented and compared to national benchmarks. Finally, the inventory of diabetes services from each tribal health department was reviewed and tribal staff introduced to the group; this enabled the providers to connect names and faces with functions. A primary contact person was also identified for each tribal health department, and this individual's name and telephone number was listed on the inventory of diabetes services. Following the formal presentation, time was provided for networking. The provider community in Maine received this program warmly! An outline of the agenda is included in the Appendix.

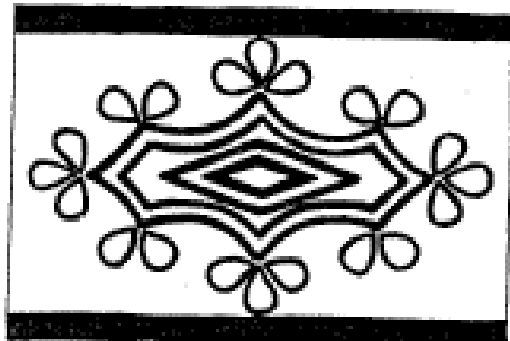
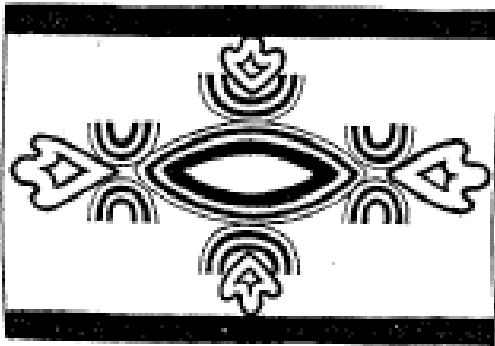
Another approach is to identify a key provider who may already be contracted by the tribe for administrative time or part-time patient care services. The Maine tribes used a physician who was well established in the local medical community to provide advice and guidance. He agreed to be the first to "pilot test" the process and materials developed for communication and exchange of patient information. He also agreed to contact other physicians to share his enthusiasm and experience with the partnership concept. It is best to start with the physicians and practice groups who communicate best with the tribal health department. These practices can influence their colleagues, over time, so that maximum buy-in is achieved.

## **Publicity and Public Relations**

The Maine tribes also used the local media to publicize events as they took place. This publicity further increased their credibility and produced additional inquiries from local physicians. Remember to plan the news coverage in advance and to utilize tribal newsletters and other means of communication where available. Another crucial step is to promptly thank all collaborators and partners involved in the process. Their ongoing support will ensure the success of your efforts.

## **Keeping Key Tribal Administrators Informed**

In Maine, the health professionals found that it was important to inform key tribal administrative staff and council members about their activities. The visible, enthusiastic support of the health directors was also very important to the project's success. Council members appreciated being informed of major events and plans in advance of news media coverage.



### **Step 5:**

### ***Working with the Primary Care Providers to Establish and Maintain Diabetes Care Partnerships***

#### **Identify the primary care providers used by diabetic patients from your tribe.**

This information can be obtained from CHS records and, oftentimes, from tribal health staff such as CHR's and community health nurses.

In Maine, the Micmac and Maliseet Tribes identified all their tribal members with diabetes when they established their registries. Some of these individuals had alternate resources such as Medicare or Medicaid, but all were included in the registry. In most cases their primary providers were easily identified.

#### **Prioritize the list as to who will be contacted first and in what sequence.**

Start with the physicians who will work with you readily and let them convince their colleagues of the benefit to the patients and convenience for the office.

#### **Make sure that the physician is aware of the tribe's interest and expertise.**

Call the physician's office and explain that you would like to talk with Dr. \_\_\_\_ about working with the tribal health department to enhance diabetes care for tribal members. Arrange a time for a telephone call with the physician and ask for participation from his/her practice, or send an initial letter followed by a call. (In some cases the first contact may be from one of your participating physician partners.) Ask the physician to designate a person in his/her office who will be your key point of contact for future communications.

Set up a meeting in the early morning, over lunch, or during the late afternoon to discuss a draft of the partnership agreement and the inventory of services to be provided by the tribe, as well as the data to be shared. Take the following materials with you to share with the physician at this initial meeting. Copies of these items are available in the Appendix:

- Provider partnership agreement
- Flow sheet or data collection form that will be used
- Inventory of tribal diabetes services
- Copy of the IHS Diabetes Standards of Care
- Copy of the ADA Provider Recognition Program measures and a brief summary of this program

#### **Use these materials to make specific logistical plans for sharing information and for making referrals to and from the health department and the provider.**

Discuss the diabetes care partnership agreement and obtain signatures. This agreement should allow you periodic access to individual records as long as a current release of information form is signed by the patient. (A sample release of information form used by the Aroostook Band of Micmacs is included in the Appendix.) In your discussion with the provider, emphasize the benefits of this cooperative working arrangement to his/her practice. *Key benefits include an expanded source of comprehensive diabetes services and periodic statistical reports tracking quality of care indicators for tribal members with diabetes.*

**Begin your case management partnership and give your providers specific individual feedback regularly.**

After the diabetes partnership agreement is in place, the tribal community health nurse (or alternate member of the health staff) will need to abstract pertinent information from the provider's medical records (i.e.: complete a "diabetes audit" on the charts of tribal members at the provider's office). When calling the provider's office, remember to ask when it is most convenient for the tribal nurse/staff member to visit the physician's office to review records. This is much easier, and less costly, for the office than copying and sending individual reports on request.

In Maine, the tribal nurses and local providers agreed upon using a "diabetes flow sheet" to abstract and update diabetes information in the provider's records. The original flow sheet remained in the patient's record at the provider's office, serving as a reminder when quarterly or annual tests and preventive exams were due. The nurses could then keep a copy of the same flow sheet in their clinic charts, and use this to enter lab results and other pertinent diabetes medical information into the RPMS PCC system as historical patient data. Through this cooperative process, both the provider and the tribal clinic charts will contain the most current diabetes care information in an organized, easy-to-locate format. A copy of the diabetes care flow sheet used in Maine is included in the Appendix.

**Do another diabetes audit after six months and provide the results to the providers acknowledging their contributions and the accomplishments of the partnership in providing comprehensive services.**

Provide periodic "diabetes data updates" to your provider "partners" in the form of statistical reports summarizing the quality of diabetes care provided for their Indian patients with diabetes. This may be done quickly and easily using the IHS Diabetes Audit program in Epi-Info or, if your tribe is utilizing and entering health-related data into RPMS, through an automated diabetes audit. Audits may be done for individual patients or groups of patients, depending on which format is most useful to the provider. (Note: Providers interested in pursuing ADA Provider Recognition may be interested in receiving a copy of the IHS Diabetes Audit Program to use in tracking and monitoring quality of care indicators for all of their patients with diabetes. Copies of the IHS Diabetes Audit Program, on disk, may be obtained from your Area Diabetes Consultants. Refer to the Appendix for more information on the ADA Provider Recognition Program.)

As part of the partnership agreement, make sure that your providers have access to resources such as monofilaments, Native American-specific diabetes education materials, and any other diabetes materials/information you have access to. There are also a number of articles written about improving diabetes care in American Indians and reducing amputations. Your Nashville Area Diabetes Consultants can help you find and share these with community providers.

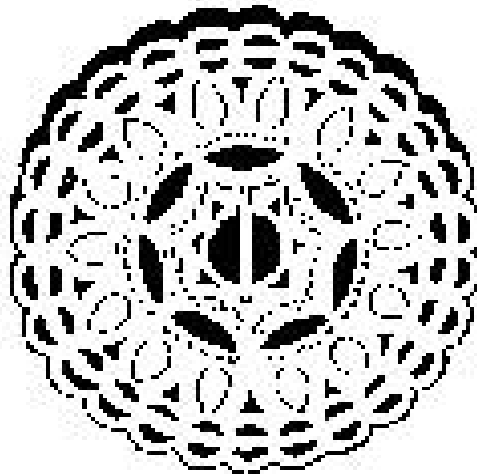


**Record and share your success with everyone involved.**

Make sure that your success in meeting national standards is known in the community and shared with tribal leaders and administrators. Take credit for the partnerships and improvements in continuity and quality of care they can produce. Ultimately, better quality of care can lead to improved health outcomes for tribal members with diabetes—a goal everyone is interested in!

**Reach out to special settings after you are established**

As you gain confidence in your partnerships, you may want to consider reaching out to include tribal members with diabetes who are living in nursing homes. Other patients with diabetes who need comprehensive preventive services are the dialysis patients who are not always seen by primary care providers. The primary care providers in the community can help you extend the benefits of your case management expertise to the specialists and nursing homes in the area.



## **Appendices**

### **A. Resource Materials**

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# IHS Standards of Care for Patients with Diabetes

(revised 12/97)



## Therapeutic Goals (for non-pregnant adults)\*

GLYCEMIC CONTROL	Normal	Goal	Action Suggested†
Fasting/preprandial glucose	110 mg/dl	80-120 mg/dl	<80or >140 mg/dl
Bedtime glucose	<120 mg/dl	100 to 140 mg/dl	<100 or >160 mg/dl
Hemoglobin A1c‡	<6 %	<7%	>8%

† Depends on individual patient circumstances

‡ Reference to a nondiabetic range of 4% to 6% (mean 5%, SD 0.5%)

## BLOOD PRESSURE AND LIPID GOALS

Systolic <130 mm Hg	Cholesterol <200 mg/dl
Diastolic <85 mm Hg	LDL-C <130 mg/dl
	HDL-C >35 mg/dl in men
	>45 mg/dl in women
	Triglycerides <200 mg/dl

\*Ref: American Diabetes Association: Clinical Practice Recommendations, 1998

## Baseline Studies

Record once on PCC Health Summary or Diabetes Flowsheet:

Height	EKG
Date of Diabetes Diagnosis	PPD

## Each Clinic Visit

Blood Pressure	Blood Glucose
Weight	Determine if HgbA1c is needed
Foot Check	Discuss all BG results (FBS or RBS, HgbA1c, SBGM records)

## Tests and Exams

<b>Annual</b>	Comprehensive Foot Exam
Creatinine	Screen for Neuropathy
Cholesterol/Triglycerides or Lipid Profile to Include LDL & HDL.	<b>Other</b>
Complete UA. Do microalbuminuria if dipstick protein is negative	HgbA1c every 3 to 4 months
Dilated Retinal Exam	C-peptide (depending on patient clinical status)
Dental Exam	

## Routine Health Maintenance

Tests and Exams	Frequency
Physical Exam	Complete exam at baseline, then routine
Pap Smear/Pelvic Exam	Yearly
Breast Exam	Yearly
Mammogram	Every 1-2 years in women ages 40-49, yearly thereafter
Rectal Exam/Stool Guaiac	Yearly in adults ≥ 40 years of age
Tobacco Use	Document current use. Make referral for smoking cessation.
Immunizations	Frequency
Flu Vaccine	Yearly
Pneumococcal vaccine	At time of diabetes diagnosis. Revaccinate all patients ≥65 yrs. If >5 yrs. since initial vaccination
dT	Every 10 years
PPD	Once after diabetes diagnosis unless known positive
Hepatitis B	Persons whose renal disease is likely to lead to dialysis or transplantation (serum creatinine ≥2.0)

## Patient Education for Self-Care Management

Nutrition Education	By an RD/Nutritionist every 6 months to 1 year
General Diabetes Education	For all patients with diabetes and their families
Exercise Education	Should include appropriate type of activity, frequency, duration, and intensity, and be individualized for each patient.
Self-Blood Glucose Monitoring (SBGM)	Patients should learn how to do SBGM; frequency must be individualized. Patients and providers should use SBGM results to determine the the pattern of BG throughout the day and use this pattern for selection and adjustments in therapy.

## Aspirin Therapy

- Consider aspirin therapy as a primary prevention strategy in high risk men & women with diabetes (family history of CVD, cigarette smoking, HTN, obesity, albuminuria, and dyslipidemia).
- Consider aspirin therapy as a secondary prevention strategy in diabetic men & women who have evidence of large vessel disease, such as history of MI, stroke, peripheral vascular disease, claudication, and angina.
- Enteric coated aspirin in doses of 160-325 mg/day is recommended.

## Tuberculosis and Diabetes Patients

- Check PPD status of all patients with diabetes.
- If no PPD placed, status is **negative**, or status is **unknown**, check status once after diagnosis of diabetes.
- **If status is positive**, check for past treatment for active TB or INH prophylaxis.
  - a) If not adequately treated, **rule out active disease**.
    - TB can reactivate in people with certain risk factors, including diabetes.
    - Reactivation can be prevented with INH prophylaxis.
    - First, be certain there is not active TB. Treatment for active TB requires multiple drugs.
  - b) **If no active disease, offer INH** with Vitamin B<sub>6</sub> (pyridoxine) except in the following circumstances:
    - Severe liver disease
    - Past adverse reaction to INH
    - Suicidal Ideation

For more Information, see "IHS Standards of Care for Tuberculosis" by Welty, T. K.. and Follas, R., *IHS Primary Care Provider*, 1989, 14: 54, 58

### **IHS Diabetes Program**

5300 Homestead Road NE  
Albuquerque, NM 87110  
Telephone: 505-248-4182  
Fax: 505-248-4188

## Pregnancy and Diabetes

### PRE-PREGNANCY

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- All women with diabetes who are in their childbearing years should receive pre-pregnancy counseling for optimizing metabolic control prior to conception. Include family planning.

### DURING PREGNANCY

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#### Throughout Pregnancy

- Pregnant women with diabetes (gestational or pre-conceptual) should do frequent self-blood glucose monitoring and maintain normal blood glucose throughout the pregnancy.

#### Screening - Early Pregnancy

- Measure blood glucose during first prenatal visit. An elevated level may detect undiagnosed pre-conceptual Type 2 diabetes.
- Perform a screening OGTT during the 1st prenatal visit regardless of gestational age for higher risk patients: women with previous GDM, previous fetal macrosomia, or family history of diabetes.

#### Screening – 24-28 Weeks Gestation

- Perform a screening OGTT at 24-28 weeks of gestation:
  - a) 50 gm oral glucose load given in the non-fasting state and a plasma glucose measurement one hour later.
  - b) A value of > 140 indicates the need for a diagnostic OGTT.
- Perform a diagnostic OGTT if indicated: Fasting blood glucose followed by a 100gm oral glucose load and plasma glucose measurements at 1 hr., 2 hrs. and 3 hrs. later.
- If the OGTT screening test is performed prior to 24 weeks and is negative, the screen should be repeated at 24-28 weeks.

### POSTPARTUM

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- At six weeks post-partum, women with GDM should be evaluated with a 2-hr OGTT after a 75gm oral glucose load to test for Type 2 diabetes
- For women who had gestational diabetes, screen annually for diabetes.

## ASSESSMENT OF DIABETES CARE, 1999

AUDIT DATE (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_ FACILITY NAME: \_\_\_\_\_  
AREA: \_\_\_\_\_ SERVICE UNIT: \_\_\_\_\_ FACILITY CODE: \_\_\_\_\_ # OF PTS IN REGISTRY: \_\_\_\_\_  
REVIEWER (initials): \_\_\_\_\_ CHART NUMBER: \_\_\_\_\_ DATE of BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

SEX: ☐1 Male ☐2 Female

DATE of Diabetes Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

DIABETES TYPE: ☐1 Type 1  
☐2 Type 2

TOBACCO USE:

- ☐1 Current User  
☐2 Never Used  
☐3 Past Use  
☐4 not documented

Referred for (or provided) cessation counseling?

- ☐1 Yes  
☐2 No  
☐3 Refused

### Vital Statistics

HEIGHT: \_\_\_\_ft \_\_\_\_in  
Last WEIGHT: \_\_\_\_lbs.

HTN(documented DX or RX):

- ☐1 Yes  
☐2 No

Last 3 BLOOD PRESSURES:

\_\_\_\_/\_\_\_\_ mm Hg  
\_\_\_\_/\_\_\_\_ mm Hg  
\_\_\_\_/\_\_\_\_ mm Hg

Examinations(in past year)

FOOT EXAM - complete:

- ☐1 Yes ☐3 Refused  
☐2 No

EYE EXAM (dilated/fundus):

- ☐1 Yes ☐3 Refused  
☐2 No

DENTAL EXAM:

- ☐1 Yes ☐3 Refused  
☐2 No

### Education (in past year)

DIET INSTRUCTION:

- ☐1 RD  
☐2 Other ☐3 Both  
☐4 None ☐5 Refused

EXERCISE INSTRUCTION:

- ☐1 Yes ☐3 Refused  
☐2 No

DM Education (Other)

- ☐1 Yes ☐3 Refused  
☐2 No

DM Therapy

Select all that currently apply:

- ☐1 Diet & Exercise Alone  
☐2 Insulin  
☐3 Sulfonylurea (tolbutamide, chlorpropamide, glyburide, glipizide, others)  
☐4 Metformin (Glucophage ®)  
☐5 Acarbose (Precoseg ®)  
☐6 Troglitazone (Rezulin ®)  
☐9 Unknown/Refused

### ACE Inhibitor Use

- ☐1 Yes ☐3 Unknown  
☐2 No

### Daily Aspirin Therapy

- ☐1 Yes ☐3 Unknown  
☐2 No

### Immunizations

FLU VACCINE (past year):

- ☐1 Yes ☐3 Refused  
☐2 No

PNEUMOVAX ever:

- ☐1 Yes ☐3 Refused  
☐2 No

Td in past 10 years:

- ☐1 Yes ☐3 Refused  
☐2 No

PPD Status:

- ☐1 Pos ☐3 Refused  
☐2 Neg ☐4 Unknown

If PPD Pos, INH Tx Complete:

- ☐1 Yes ☐3 Refused  
☐2 No ☐4 Unknown

If PPD Neg. Last PPD:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of last EKG: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Laboratory Data

HbA1c (most recent): \_\_\_\_.%

Date obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_

HbA1c (next most recent): \_\_\_\_.%

Date obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_  
or, if no HbA1c available...

Last 3 BLOOD SUGARS:

\_\_\_\_ mg/dl  
\_\_\_\_ mg/dl  
\_\_\_\_ mg/dl

Most recent serum value in the past 12 months:

Creatinine: \_\_\_\_ mg/dl  
Total Cholesterol: \_\_\_\_ mg/dl  
LDL Cholesterol: \_\_\_\_ mg/dl  
Triglycerides: \_\_\_\_ mg/dl

URINALYSIS:

- ☐1 Yes ☐3 Refused  
☐2 No

PROTEINURIA:

- ☐1 Yes (1+ or more)  
☐2 No (Neg or trace)

MICROALBUMINURIA:

- ☐1 Pos  
☐2 Neg  
☐3 Not tested

Is self monitoring of blood glucose documented in chart?

- ☐1 Yes  
☐2 No  
☐3 Pt refuses to monitor

Is pt. Participating in SDM? :

- ☐1 YES  
☐2 No  
☐3 Unable to determine

Local Option question:

**American Diabetes Association  
Provider Recognition Program  
Measures for Adult Patients**

<u>Measure</u>	<u>Frequency</u>	<u>Data Source<sup>^</sup></u>	<u>Necessary % of Pts Achieving Measure</u>	<u>Weighting For Adult Pts.</u>
1. HbA1c	≥ 1 time/yr	MR	93%	10.0 points
Proportion w/HbA1c< 8%			40%	2.5 points
Proportion w/HbA1c< 10%			84%	2.5 points
2. Eye exam	1 time/yr	MR	40%	10.0 points
3. Foot exam	≥1 time/yr	MR	74%	10.0 points
4. Blood pressure frequency	≥ 2 times/yr	MR	97%	10.0 points
Proportion diastolic pressure ≤ 90 mm Hg			96%	5.0 points
5. Urinary Protein/Microalbuminuria	1 time/yr	MR	31%	10.0 points
6. Lipid profile	1 time/yr	MR	52%	10.0 points
7. Self-management education	Annual	PS	90%	10.0 points
8. Medical nutrition therapy	Annual	PS	90%	10.0 points
9. Self-Monitoring of Blood Glucose	Yes	PS		
...non-insulin treated patients			50%	1.0 point
...insulin treated patients			97%	4.0 points
10. Tobacco status & counseling referral**	Yes	PS	76%	10.0 points
11. Patient satisfaction	Excellent, Very Good, or Good (on a scale of Excellent to Poor for each of the five components)	PS	<u>Pro.* Retro.*</u>	
...diabetes care overall			58% 42%	1.0 point
...diabetes questions answered			56% 41%	1.0 point
...access during emergencies			46% 33%	1.0 point
...explanation of lab results			50% 40%	1.0 point
...courtesy/personal manner of provider			77% 68%	1.0 point
Total				110.0 points
Score Needed to Achieve Recognition				74.0 points
Score Needed to Achieve Recognition with Distinction				92.0 points

Notes:

<sup>^</sup> MR = medical record or administration data system; PS = patient survey

\* Pr. = prospective survey; Retro. = retrospective survey

\*\* For this measure, the denominator for patients receiving a referral for tobacco cessation will be the number of patients from the applicant's sample who report that they use tobacco.

# PROVIDER RECOGNITION PROGRAM

1600 Duke Street  
Alexandria, Virginia 22314  
Tel: 703 549-1500 x2202  
Fax: 703 683-1839  
<http://www.diabetes.org>

March 24, 1999

Dear Colleague:

In 1997, the American Diabetes Association (ADA) and the National Committee for Quality Assurance (NCQA) launched the Provider Recognition Program (PRP), a program designed to identify and commend physicians providing quality diabetes care. The purpose of this letter is to update you on this important program and our participation in an exciting national coalition called the Diabetes Quality Improvement Project (DQIP).

DQIP is a coalition of organizations, including ADA, NCQA, the Health Care Financing Administration (HCFA), Foundation for Accountability, American Academy of Family Physicians, American College of Physicians, and Veterans Administration, that have identified a set of evidence-based, practical diabetes measures to be used nationwide. Coalition participants have agreed that these measures will be incorporated into the programs and activities of their respective organizations and HCFA will mandate reporting of DQIP measures by their participating plans in the year 2000. We are happy to report that the PRP measures are already consistent with the measures designated by DQIP and, as a result, Recognized physicians and healthcare groups now have a headstart in assessing their performance relative to DQIP.

Due to both the DQIP initiative and to healthcare system applications that are nearly complete, we expect the number of Recognized physicians will increase dramatically this year. We expect that in a few months over 2,000 physicians will have achieved Recognition. Our list of Recognized physicians includes both endocrinologists and general practice physicians in solo practice, within group practices, in hospital based settings, and within managed care organizations.

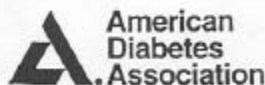
We encourage you to read the enclosed questions and answers document and then use the tear-off mailer within the enclosed brochure to request an application package. Application to become Recognized can be achieved at the same time you assess your practice to determine compliance with the nationally accepted DQIP performance measures. In addition to promotion through ADA's website, publications, and regional offices, Recognized physicians receive a media kit and ADA's assistance to announce their Recognition status and thereby market their commitment to quality care. If you have any questions about the PRP, please call 703/549-1500 extension 2202, or send e-mail to [prp@diabetes.org](mailto:prp@diabetes.org).

We hope you will seek Recognition so that the quality healthcare you provide will achieve the Recognition it deserves.

Sincerely,



Mark Molitch, MD  
Chair, Provider Recognition Policy Committee



Cosponsored by  
**NCQA**

National Committee for Quality Assurance

## QUESTIONS & ANSWERS

### OVERVIEW

#### *What is the Provider Recognition Program?*

The American Diabetes Association's (ADA) Provider Recognition Program, cosponsored by the National Committee for Quality Assurance (NCQA), is a voluntary program for individual physicians or groups of associated physicians who provide care to people with diabetes. Physicians can achieve Recognition by submitting data that demonstrates they are providing quality diabetes care. The Program will assess 11 key measures (see p. 6) that were carefully defined and tested for their relationship to improved care for people with diabetes.

#### *Why was the Provider Recognition Program developed?*

The Provider Recognition Program is a key strategy for the ADA in fulfilling its mission to improve the lives of all people affected by diabetes. The Program goal is to improve care given to people with diabetes by 1) focusing the health care community, purchasers of health care, consumers, and other interested organizations on the 11 key measures of diabetes care, and 2) identifying, motivating, and commending physicians who are providing quality diabetes care.

In addition, in this era of cost-consciousness in health care, identification of the key measures of diabetes care will help ensure that quality is integrated into diabetes disease management systems nationwide. Physicians, for example, who adhere to specific care guidelines, incorporating these key measures, would be expected to have diabetes patients who are less likely, in general, to develop devastating and costly complications such as kidney disease, heart disease, stroke, amputations and blindness.

#### *Who can apply for Recognition?*

An individual physician (MD or DO) who provides direct, continuing care for at least 35 diabetes patients in a 12-month period may apply for Recognition. In addition, a group of two or more physicians who by formal arrangement share responsibility for a common panel of patients from which a sample can be drawn are eligible to apply as a group. Or, a group of two or more physicians having comprehensive programs or protocols directly related to the management and treatment of diabetes, which are maintained across all physicians are also eligible to apply as a group. Group applicants will submit data for 35 patients per physician for groups with two to six physicians and 210 patients for a group of seven or more physicians. A physician within a group practice may also apply for Recognition as an individual provider.

# Diabetes Data and Case Management For CHS Providers

(includes information on complications)

## I. Demographic data

Name, address, telephone of patient

Basic demographic information:

Gender, birth date, SS#

Insurance Status (dates)

Primary Insurance

Secondary Insurance

AOB/Release of Information

This information enables the health department to establish and maintain an active diabetes registry, and to contact individual patients and their primary care providers. It also provides information on insurance status and allows for release of patient information to the tribal health department.

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## II. Diabetes Data

Type of Diabetes (type1, type2)

Date of diagnosis

Provider name and address

Status (active, inactive [moved, deceased--date])

Date of last visit

Diabetic Medications

Other Illnesses:

High Blood Pressure

Coronary Artery Disease

CHS data & PHN/CHR knowledge can be used to identify patients & related information.

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## III. Amputation Prevention Section

Date of last foot risk assessment: \_\_\_\_\_

Findings: Low Risk Y / N

High Risk Y / N

(insensate, ulcer history, previous amputation, deformity including Charcot foot)

Amputation Y / N

If "Y" : levels of amputation, R or L, and date(s) of amputation

Foot Care Provider Y / N

Name/Address

Does patient use special footwear, inserts, prosthesis, etc. Y / N

This assessment should be completed yearly by the provider. The tribal health dept. can also assist in providing basic foot care, educating the patient to ask for these services, and in providing case mgmt. services for the patient and provider to ensure that foot care services are made available.

This information can be obtained from the patient and/or providers. It will allow tribal case managers to help high-risk patients access regular foot care and preventive footwear. It can also be used for tracking/monitoring amputations.

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#### IV. Blindness Prevention

Date of last dilated eye exam  
Name of eye exam provider  
Findings:  
No retinopathy  
Background retinopathy  
Pre-proliferative retinopathy  
Proliferative retinopathy/macular edema  
Date of referral to Ophthalmologist  
Laser Therapy Y / N

This information can be obtained from the patient and/or provider.

It will allow the tribe to report new cases (incidence) of laser therapy and assist tribal members in accessing preventive eye care services.

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#### V. Kidney Preservation Information

Taking medication for Hypertension Y / N  
ACE Inhibitor Y / N  
Last measured BP  
Last HBA1c: Date and Value  
Self monitoring frequency  
Last Routine Urinalysis: date and result of urine protein  
If protein negative, date and result of last microalbuminuria screen  
Date and result of latest serum creatinine  
Date ESRD treatment began and type:  
(hemodialysis, CAPD, transplant)

This information will allow tribal case managers to report the number of new ESRD cases, but also to ensure that tribal members receive care and education necessary for prevention and early detection of ESRD.

Tribes can help providers and selected patients who may benefit from diabetes education and self monitoring.

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#### VI. Referrals Needed

Diabetes Education:  
Serum Blood Glucose Monitor Training  
Nutrition Counseling  
Exercise Counseling  
Other Topics: \_\_\_\_\_  
Dental Exam  
Physical Rehab.  
Social Services  
Transportation  
Other: \_\_\_\_\_

This section will allow primary care physicians to refer tribal patients to the health department for services.

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## DIABETES DATA AND CASE MANAGEMENT FORM FROM CHS PROVIDERS

<b>DEMOGRAPHIC DATA</b>	
First Name :	
Last Name:	
Address: Phone Number	( )
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	___/___/___ (MM/DD/YY)
SSN:	
Primary Insurance Name:	Date: ___/___/___(MM/DD/YYYY)
Secondary Insurance Name:	Date: ___/___/___(MM/DD/YYYY)
AOB:	To whom: Date: ___/___/___(MM/DD/YYYY)
Release Information:	<input type="checkbox"/> Yes <input type="checkbox"/> No

DIABETES DATA	
Type of Diabetes:	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Date of Diabetes Diagnosis:	____/____ (MM/YYYY)
Provider Name/Address: Phone Number:	(      )
Patient Status:	<input type="checkbox"/> Active <input type="checkbox"/> Inactive (moved, deceased)
Date Last Visit to Provider	____/____/____(MM/DD/YYYY)
Diabetes Medications:	<input type="checkbox"/> Insulin <input type="checkbox"/> Insulin secretagogues (sulfonylureas, Prandin) <input type="checkbox"/> Metformin <input type="checkbox"/> Insulin sensitizers (Troglitazone) <input type="checkbox"/> Absorption modifiers <input type="checkbox"/> Other
Other Illnesses:	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Coronary Artery Disease

AMPUTATION PREVENTION	
Date of Last Foot Assessment:	___/___/___ (MM/DD/YYYY)
Findings/History:	<input type="checkbox"/> Insensate <input type="checkbox"/> Ulcer Hx. <input type="checkbox"/> Previous Amputation <input type="checkbox"/> Deformity
Risk status:	<input type="checkbox"/> High <input type="checkbox"/> Low
Amputation(s):	<input type="checkbox"/> Right (Date ___/___/___) <input type="checkbox"/> Left (Date ___/___/___)
Foot Care Provider (Podiatry):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name/Address:	
Currently use special footwear, inserts, prosthesis:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

BLINDNESS PREVENTION	
Date Last Dilated Retinal Exam:	___/___/___ (MM/DD/YYYY)
Name of Eye Exam Provider:	
Findings:	<input type="checkbox"/> No retinopathy <input type="checkbox"/> Background retinopathy <input type="checkbox"/> Preproliferative retinopathy <input type="checkbox"/> Preproliferative retinopathy/Macular edema
Referral to Ophthalmologist for Treatment:	___/___/___ (MM/DD/YYYY)
Laser Therapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

KIDNEY PRESERVATION INFORMATION	
Taking medication for Hypertension:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
ACE-Inhibitor:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Last Blood Pressure Date/Value:	____/____/____(MM/DD/YYYY) Sys. _____ Dia. _____
Last HbA1c Date/Value (%):	____/____/____(MM/DD/YYYY) _____.____ (%)
Self Monitoring Frequency:	____# times per day
Urine Protein Date/Value:	____/____/____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative
If Urine Protein = Negative, Last Microalbumin Screen Date/Value:	____/____/____ (MM/DD/YYYY) ____ (Units_____)
Last Serum Creatinine Date/Value:	____/____/____ (MM/DD/YYYY) ____mg/dl
ESRD Treatment Begun Date:	____/____/____(MM/DD/YYYY)
ESRD Treatment Begun Type:	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> CAPD <input type="checkbox"/> Transplant
REFERRALS NEEDED	
Diabetes Education:	<input type="checkbox"/> Blood Glucose Monitoring Training <input type="checkbox"/> Nutrition Counseling <input type="checkbox"/> Exercise Counseling <input type="checkbox"/> Physical Rehabilitation <input type="checkbox"/> Dental Exam
Other Referrals:	<input type="checkbox"/> Social Services

## Diabetes Care Flow Sheet

<b>EACH VISIT</b>	Date							
	Weight							
	BP							
	BS							
	Foot Check							
<b>QUARTERLY</b>	HgbA1c							
<b>ANNUAL</b>	UA							
	Microalb. (test only if UA neg/trace)							
	Serum Creat.							
	Cholesterol							
	HDL/LDL							
	TG							
	Flu Vaccine							
	Phys. Exam							
	Dental Exam							
	Eye Exam							
	Foot Exam (sensation circulation)							
	Rectal/Guaiac (age >=40)							
	Nutrition							
	Exercise							
	DM Educat. (other)							
S.B.G.M.								
<b>Status of Diabetes Complications</b>	Amputation (type/location)							
	Dialysis (type) or Transplant							
	Retinopathy (specify type/Laser Rx?)							
<b>Women Only</b>	PAP/Pelvic							
	Breast Exam							
	Mammogram (age >=40)							

**PATIENT NAME:** \_\_\_\_\_

**CHART # :** \_\_\_\_\_

**DATE OF DM DIAGNOSIS:** \_\_\_\_\_

**BASELINE INFORMATION:**

Height: \_\_\_\_\_

EKG: (date): \_\_\_\_\_

PPD (date, +/-, Rx): \_\_\_\_\_

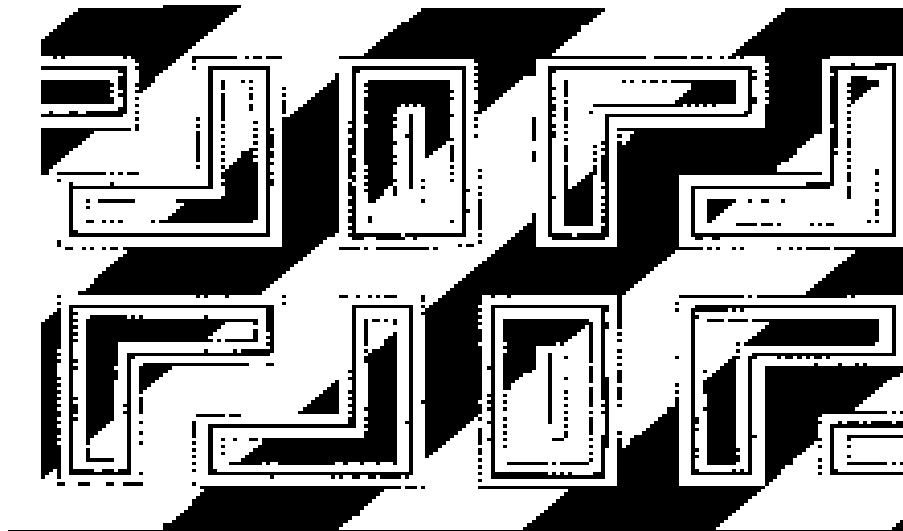
Pneumovax (date): \_\_\_\_\_

dT (date): \_\_\_\_\_

Tobacco Use (Y/N/Past Use): \_\_\_\_\_

Smoking Cessation Provided:  
(Y/N/Refused/NA): \_\_\_\_\_

## Samples from Maine



**(SAMPLE INVENTORY OF DIABETES SERVICES)**  
**Maine Tribal Health Department Diabetes Resources**

**Diabetes education** classes and individual instruction are available. Upon physician diagnosis of diabetes, the Tribe provides a blood glucose meter and test strips and will facilitate access to all available resources.

**Nutrition counseling** at home, in the hospital, or at the Tribal Clinic can be provided upon referral from the provider. (Details are requested regarding the patient's individual needs and pertinent lab results, height/weight measurements, etc.)

The Tribe maintains a **wellness center** for individual and group exercise programs. Referrals are available for water aerobics. High-risk individuals, as well as diagnosed diabetic patients, are encouraged to participate. A physician's approval is required to participate in these programs.

**Eye exams and dental examination and care** are coordinated through Contract Health Services.

**Immunizations**, to include pneumovax, Td, and yearly flu shots, can be administered at the Tribal Clinic.

The Tribal Health Department can coordinate **transportation** as needed. Community Health Representatives accompany individuals to office visits. This close contact provides both the patient and the family with a better understanding of the provider's plan of care.

**Home blood sugar and blood pressure checks** are provided routinely for diabetic patients. Medication cards for individuals include pertinent lab values and blood pressure measurements.

**HbA1c and lipid profiles** are available through the Tribal Clinic. These values are recorded on the medication cards. Providers can refer individuals for these tests.

**Foot exams** are performed yearly on a routine basis. Ongoing foot care is coordinated through podiatry. Footwear can be provided for diabetic individuals as an incentive for maintaining quality care with regular follow-up.

**Diabetes screening** is held periodically in the community. Individual referrals from physicians are welcome.

**Mental health and substance abuse** counseling is available upon referral.

**How does a primary care provider refer?**

**Call, write, or fax referrals to:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

## AGENDA AND OBJECTIVES FOR INITIAL CME PROGRAM

### *Effective Treatment & Quality Benchmarks in Diabetes Care*

#### **I. Overview of New Developments in Type 2 Diabetes - 50 minutes**

##### Objectives:

Participants will be able to:

- identify the mechanisms of action of new oral agents for diabetes,
- relate these to the pathophysiology of Type 2 diabetes, and
- establish therapeutic targets for HbA1c, lipids, and blood pressure based on the latest research studies.

#### **II. Quality Benchmarks in Diabetes Care - 40 minutes**

##### Objectives:

Participants will be able to:

- describe the high rates of diabetes in American Indians,
- identify the recommendations for periodic screening and monitoring for diabetes complications, and
- review the local and national benchmarks for diabetes care as measured by the Indian Health Service Diabetes Care and Outcomes Audit and the American Diabetes Association.

#### **III. Review of Tribal Diabetes Inventory with Introductions of Tribal Staff - 10 minutes**

(A 20 minute discussion time is incorporated into the program.)

##### Notes:

1. The Maine tribes prepared packets for each participant. These packets included information about the IHS Standards of Care and Audit, the ADA Provider Recognition Program criteria, the tribal inventories, and articles about quality diabetes care and current therapies for Type 2 diabetes. An article from the *Journal of Family Practice* about decreasing amputations in an IHS setting was also included.
2. CME credits require advance planning. Accrediting agencies, including local hospitals and the IHS Clinical Support Center, require written objectives (such as those listed above) and a CV for each instructor, as well as statements to disclose all sponsorship. Be prepared to work through this process several months in advance.
3. Pharmaceutical representatives can be very helpful to tribes. Most companies are happy to assist in providing educational sessions to update primary care providers. They can defray the costs of speakers and provide meals. However, the local representatives need lead time to make arrangements and their contributions must be disclosed in the information about CME credits. Federal officials cannot ask for such help, but tribes can work directly with pharmaceutical representatives to coordinate activities.

**AROOSTOOK BAND OF MICMAC INDIANS**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I \_\_\_\_\_, hereby authorize \_\_\_\_\_ and  
(Patient) (Provider/Medical Group)

it's employees and agents to disclose and discuss my medical records relating to:

\_\_\_\_\_ with \_\_\_\_\_  
(Purpose) (Receiving individual or entity)

Please forward:

\_\_\_\_ All of my medical record information, including history, dates, course, and summary of treatment received.

\_\_\_\_ Medical records on file from other health care practitioners.

\_\_\_\_ Statements I have added to my medical records, with responses, if any.

\_\_\_\_ Only: \_\_\_\_\_

This information may be used for:

\_\_\_\_ Ongoing treatment/aftercare

\_\_\_\_ Other: \_\_\_\_\_

My consent to release these records is effective until 30 months from today, and I authorize future disclosures regarding these records to the same individuals or entities during this time period.

I understand that I may revoke all or part of this authorization at any time by notifying the Aroostook Band of Micmacs in writing, subject to the right of anyone who received or disclosed information prior to receiving my revocation. The agency and I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences. I may have a copy of this form upon request. I may cross out any words on this form with which I disagree.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Witnessed \_\_\_\_\_  
(Patient/legal representative)

**DIABETES CARE PARTNERSHIP AGREEMENT  
BETWEEN**

**Partnership Provider and the Aroostook Band of Micmacs Health Department**

**MICMAC HEALTH DEPARTMENT KEY CONTACT: Jerolyn Boutilier/ R.N.C.**  
**TELEPHONE #: (207) 764-7219      FAX: (207) 764-7768**

**OFFICE MANAGER CONTACT: \_\_\_\_\_**  
**TELEPHONE#: \_\_\_\_\_ FAX #: \_\_\_\_\_**

**BRIEF HISTORY:**

The Aroostook Band of Micmac Indians (ABMI) became a federally recognized Tribe in November of 1991, and has had a comprehensive health program funded by the Indian Health Service Nashville Area Office since the summer of 1992. The Tribe is still considered a relatively new tribal health contractor, in that it is continually seeking to refine and redefine its ability to administer and manage its health programs.

**PROJECT PURPOSE:**

The Micmac Health Department (MHD), in conjunction with the Aroostook Band of Micmac Indians (ABMI), has been awarded a Diabetes Prevention Grant through the United States Public Health Service. This proposal has allowed the MHD to address a major health problem plaguing many of the Micmac Tribal Community members. The grant provides the Micmac Health Department, and your office, the opportunity to coordinate a unique array of diabetes services for Micmac patients. Some of these services include:

- |                                                            |                                                                                                                               |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| • Effective client case management                         | • Diabetes data surveillance and <del>information</del> <b>data only can be placed</b> coordinate crucial patient information |
| • Comprehensive diabetes prevention and education services | • Development of a quality assurance program to promote continuity of diabetes care                                           |
| • Coordination of referrals on an agency-to-agency level   |                                                                                                                               |

Copies of the quality indicators utilized by the American Diabetes Association Provider Recognition Program, and the Indian Health Services Diabetes Standards of Care, are attached for your information.

**PARTNERSHIP SERVICES PROVIDED:**

Outlined is a proposed list of services to be provided by the MHD and the primary care provider:

**MICMAC HEALTH DEPARTMENT**

- Data abstraction from provider medical records
- **Coordinated referral system**
- Case management for Micmac patients
- Use of comprehensive Diabetes Flow Sheets
- Data analysis and periodic reports to provider
- Diabetes prevention/education services and patient follow-up
- **Shared quality assurance standards**

**PROVIDER**

- Shared client data
- **Coordinated referral system**
- Patient continuity of care
- Client medication info.
- Create standards of care in discharge planning, aftercare, assessment procedures
- **Shared quality assurance standards**

Through use of the flow sheet, the Micmac Health Department will be able to assist in updating your office charts and records to reflect the most current information on Micmac patients. This will enable you to provide effective and comprehensive diabetes care.

The Micmac Health Department looks forward to providing your office with the necessary data generated through this partnership alliance. We would like to take this opportunity to thank you for your assistance and cooperation in assisting our agency in improving continuity and quality of diabetes care for Micmac tribal members.

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**Health Care Provider**

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**Date**

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**Micmac Health Department Contact Provider**

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**Date**

- **Both parties will share information with regard to Micmac Tribal Community members upon receipt of a current "Release of Information Form."**

**DIABETES CARE PARTNERSHIP AGREEMENT  
BETWEEN**

**Dr. \_\_\_\_\_  
and the \_\_\_\_\_ Tribal Health Department**

**Purpose:**

**The \_\_\_\_\_ Tribal Health Department has received a diabetes prevention grant from the United States Public Health Service. Diabetes is a major health problem for many of our tribal members. The grant has provided us with the opportunity to begin a case management program to benefit our tribal members and to help you provide the comprehensive range of preventive services necessary for quality diabetes care. In order to coordinate our unique resources with those of your office, we need your help.**

**We have outlined an inventory of the services we can provide, along with a brief data collection plan to help coordinate referrals that you may wish to make. Our records indicate that you see \_\_\_\_ # \_\_\_\_ members of the \_\_\_\_\_ Tribe for diabetes care. We would like to meet with you and your staff at a convenient time to develop a case management and data sharing partnership that can facilitate continuity of care. We look forward to providing you with periodic summary reports as well as individual reports on your Indian patients.**

**As a resource for your office, we have attached copies of the quality indicators used by the American Diabetes Association Provider Recognition Program, and the Indian Health Service Diabetes Standards of Care. The Indian Health Service standards are very similar to those of the American Diabetes Association but pertain more precisely to the needs of our tribal members. We look forward to sharing information periodically about the quality of diabetes care for our tribal members.**

**We thank you in advance for all your help and cooperation in this effort. It is our hope that by working together we can achieve the best possible long term outcomes for our tribal members with diabetes.**

**Role/Responsibilities: Tribal Health Department \_\_\_\_\_**

**The \_\_\_\_\_ Tribal Health Department will provide case management coordination for tribal members with diabetes, including the services outlined in the attached description.**

**Using the flow sheet attached, or a similar one, the tribal health department will maintain and update your patient charts to ensure that your records reflect complete information regarding the patient's care, enabling you to provide comprehensive diabetes care efficiently.**

**The primary contact for the \_\_\_\_\_ Tribal Health Department will be:**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Phone**

**Role/Responsibilities: Physician Office, Dr. \_\_\_\_\_**

**The office will share information about the care of tribal members with diabetes upon receipt of a current release of information form.**

**The office will allow the tribal case manager access to charts periodically to assure that all clinical information is current.**

**The primary contact for Dr. \_\_\_\_\_'s office will be:**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Phone**

**Signatures:**

\_\_\_\_\_  
**Tribal Health Department**

\_\_\_\_\_  
**Physician's Office/Practice Group**

\_\_\_\_\_  
**Date**